Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Mahmood Poushesh, DC 9898 Bissonnet, Ste. 152 Houston, TX 77036	MFDR Tracking #: M4-07-7133-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: American Home Assurance Co. Rep Box #: 19	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "AIG Claims Services had denied payment for date of service: 05/06/2007. using reason code 42 "Charges exceed our fee schedule or maximum allowable amount and There [sic] position remain the same."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $841.50
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The provider filed a DWC-60 seeking a Request for Medical Dispute Resolution for a Functional Capacity Evaluation performed on May 9, 2007 under CPT No. 97750FC. The provider seeks reimbursement of $841.50. The carrier initially took final action on May 29, 2007 and recommended no reimbursement. The carrier received a request for reconsideration and prepared an EOR in response to it on June 11, 2007. The carrier's EORs are part of the provider's DWC-60 packet. The carrier's position remains the seame as identified in its EORs.

Principle Documentation:

1. DWC-60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
05/09/07	97750-FC ($28.69 x 125% = $35.87 x 8 = $286.96)	42, W1, 172	1- 3	$286.96
Total Due:				$286.96

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This service was denied by the Respondent with reason code "42 – Charges exceed our fee schedule or maximum allowable amount"; "172 – Payment is adjusted when performed/billed by a provider of this specialty; "W1 – Workers Compensation State Fee Schedule Adjustment."
2. The Respondent denied the FCE on the basis that the Requestor exceeded the fee schedule or maximum allowable amount and that payment is adjusted when performed/billed by a provider of this specialty. Per Division Rule at 28 Texas Administrative Code Section 134.202(b), payment is based on the Medicare payment system and not the provider specialty. Per Division Rule at 28 Texas Administrative Code Section 134.202(e)(4), reimbursement for FCE's shall be for up to a maximum of four hours for the initial test or for a Commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. The Requestor stated that this was the 2nd FCE; therefore, a maximum of two hours should be billed and reimbursed. Therefore, per Division Rule at 28 Texas Administrative Code Section 134.202(c)(1) reimbursement in the amount of $286.96 is recommended.
3. Per review of Box 32 on CMS-1500, zip code 77036 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $286.96 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	3/7/08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.